

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35736

State File No.

FILED NOV 13 1953

BIRTH NO. _____ REG. DIST. NO. 143 PRIMARY REG. DIST. NO. 556 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Howell</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>		
b. CITY OR TOWN <u>Wilson Springs</u>		c. LENGTH OF STAY (in this place) <u>6 yrs</u>	c. CITY OR TOWN <u>Wilson Springs</u> 0460		
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If rural give location) <u>R.F.D.</u>		

3. NAME OF DECEASED (Type or Print) a. (First) <u>Lee</u> b. (Middle) <u>Collins</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>10-19-53</u>		
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>1-25-1886</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>24</u>	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (State or foreign country) <u>Douglas Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13. FATHER'S NAME <u>Lee Collins</u>		13b. MOTHER'S MAIDEN NAME <u>Helen Johnson</u>		14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>442</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Chas. Collins, Wilson Sprgs., Mo</u> ADDRESS _____		
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Cancer Stomach</u>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer Stomach</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 mo</u>
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>151X</u>	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
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22. I hereby certify that I attended the deceased from 2-10-1953 to 10-19-1953, that I last saw the deceased alive on 10-16-1953, and that death occurred at 4:00 m., from the causes and on the date stated above.

23a. SIGNATURE <u>J.B. Stebbins M.D.</u> (Degree or title)		23b. ADDRESS <u>Walt Plains</u>		23c. DATE SIGNED <u>10-21-53</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>10</u>	24b. DATE <u>10-21-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hillside</u>	24d. LOCATION (City, town, or county) (State) <u>Hansb. Mo</u>		
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DATE REC'D BY LOCAL REG. _____	REGISTRAR'S SIGNATURE <u>W. G. Bridges</u>	GENERAL DIRECTOR'S SIGNATURE <u>Robertson, Matthew Mo</u> ADDRESS _____			
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

D. D. Roberts

Licensed Embalmer No. *3427*

P. O. Address *Leesport, Pa.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.